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Abstract

The present study provides a comprehensive review of the psychological literature on the barriers to seeking formal and informal mental health help-seeking for Asian immigrants and Asian Americans. Within the present review, the researcher utilizes Bronfenbrenner's Ecological Systems Theory (1992) of human development (macrosystem, exosystem, mesosystem, and microsystem) to organize eight ecological factors that influence Asian immigrants and Americans' mental health help-seeking behaviors including; ethnicity, generational influence (acculturation), culture, stigma/shame associated with mental health, family structure/environment, social support, gender, and age. The researcher offers a proposed model of treatment help-seeking and provides directions for future research. The latter section of this study focuses on the methodological problems inherent in the study of Asian immigrant and American mental health help-seeking. The implications and suggestions for current clinical research, training/education, and practice are explored.

Acknowledgments

A friend recently complemented me by saying, “Your parents must be very proud of you because you are so successful in life.” Although very flattering, this statement did not resonate within me. Yes, I am thrilled to be where I am currently, but I am truly thankful for the plethora of opportunities that I have been offered. My accomplishments are not a reflection of my abilities or talents, instead a product of the sacrifices and hard work of my family. For these reasons, I have been passionate about this study and eagerly await conducting further research on this topic.

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INTRODUCTION

According to recent statistics, only 17 percent of Asian Americans in the United States sought some form of assistance for psychological problems and less than 6 percent sought help from a mental health provider (U.S. DHHS, 2001). Unfortunately, research indicates this phenomenon will continue unless changes are made within the training and practice of clinical psychology (Hall, 1997). This is troubling because Asian and Asian ancestry populations in the USA are estimated to increase from 10.7 million to 33.4 million over the next 50 years.

Access to services is certainly a factor, but an emerging critique has focused on the world view of those providing services. Psychologists must recognize that psychological concepts and theories that underlie treatment modalities and assumptions about wellness were developed from a predominantly Western-American (viz., North American) perspective and may be limited in their utility to culturally diverse populations (D.W. Sue, et al., 1999). Hall (1997) suggested that mainstream Euro-American psychology may become "culturally obsolete" unless it is revised to reflect a multicultural perspective (p. 642). Counter to these arguments, the dominant paradigm in clinical psychology is still based on an understanding of Western, Anglo, middle class, Protestant persons who are young, attractive, verbal, intelligent and successful (YAVIS; Howes, 2009).

The purpose of this paper is to provide a comprehensive review of the psychological literature on the barriers to seeking formal and informal psychological help of Asian Americans in the United States. The terms professional or formal help-seeking will be used interchangeably to describe individuals seeking psychological services provided by a mental health professional (i.e., psychologist, psychiatrist, counselor, etc.). The terms non-professional and informal help-seeking will be used interchangeably to describe other services that are not provided by mental

health professionals such as support from family members, religious members or priests, or other medical professionals.

Within the present review, the researcher utilizes Bronfenbrenner's Ecological Systems Theory (1992) of human development to organize the ecological factors involved in Asian Americans' formal help-seeking. Specifically, this review will be organized into the four categories of Bronfenbrenner's Ecological Systems Theory which include the macrosystem, exosystem, mesosystem, and microsystem. Research included in the macrosystem will focus on larger influences on Asian Americans' decision to seek professional psychological help; I will focus particularly on ethnicity and generational influences like acculturation. In the exosystem, culture, stigma and shame will be discussed as barriers to seeking formal psychological help. The mesosystem will include factors such as family structure, environment and social support. The microsystem will focus on the individual's gender and age.

Previous studies have used similar approaches to conceptualize working with clients from diverse backgrounds. For example, a *network-episode approach* to understanding help-seeking where systemic models has been used to organize multiple factors that influence a person's likelihood to seek professional psychological treatment (Abe-Kim, et al., 2007; Hall & Okazaki, 2002; D.W. Sue, et al., 1999; Sue & Terry, 2005).

The latter half of this paper will focus on the methodological problems inherent in the study of Asian American mental health and help-seeking. Specifically, problems with research using aggregated ethnic/racial samples that do not account for interaction effects of individual factors will be discussed. In addition, the consequences of not providing culturally sensitive psychotherapy are discussed. The researcher will present the implications of the current

"Western" psychological paradigm on current clinical psychology education and training, research, and practice.

REVIEW OF THE LITERATURE

Ecological Systems Theory (Bronfenbrenner, 1992) was applied to analyze the factors that influence Asian immigrants and Asian Americans' patterns of seeking mental health treatment. Previous studies have also applied a systemic perspective to understand different factors that influence Asian Americans' decisions to seek mental health services: these include the network-episode model (Abe-Kim, Takeuchi, & Hwang, 2002) and Anderson's Sociobehavioral Model (SBM; 1995); both systemically organize the multitude of factors that play integral roles in a person's likelihood to seek professional psychological treatment (Abe-Kim, et al., 2007; Hall & Okazaki, 2002; D.W. Sue, et al., 1999; S. Sue & Terry, 2005).

Macrosystem

The macrosystem or broadest level of influences includes global and societal influences on individuals (Bronfenbrenner, 1992) such as research on ethnicity and generational research or on immigration influences such as acculturation.

While underutilization of therapy among people of Asian ancestry is a well known phenomenon (Abe-Kim et al., 2007), effective policies or interventions to address this remain unarticulated. The majority of research has aggregated Asians regardless of immigration status, geographic, linguistic, cultural, or ethnic variation. Until 2000, the census aggregated Pacific Islanders and Asians despite overwhelming sociocultural evidence of their distinctiveness (Srinivasan & Guillermo, 2000). The Office of Management and Budget (OMB) defines Asian as "A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes 'Asian Indian,' 'Chinese,' 'Filipino,' 'Korean,' 'Japanese,' 'Vietnamese,' and 'Other Asian'" (U.S. DHHS, 2001).

Furthermore, the sociopolitical category "Asian" presents particular challenges for psychological researchers and mental health providers because of the resultant ambiguity in classifying Asian Americans. For example, Okazaki and Hall (2002) articulate the differences between the concept of Asian American and an internalized pan-Asian American ethnic identity. They define pan-Asian American ethnic identity as one imbedded in an understanding of how out-groups label and aggregate them with Americans of various Asian national origins in the United States. This example highlights the difficulty in disaggregating Asian ethnicities because it depends on the individuals' consciousness of cultural congruity (e.g., a recent immigrant from China versus a 4th generation person of Chinese ancestry living in California). Research has

relied on self-reports of ethnic identities to help disaggregate Asian Americans into specific ethnicities. This decision is primarily based on individuals' consciousness and identity.

One outcome of the aggregation paradigm is decreased specificity and the exclusion of important ethnic demographic information. The few studies that have disaggregated Asian ethnicities have primarily focused on Chinese, Japanese, Vietnamese, and Korean populations (Okazaki & Hall, 2002). The benefit of employing such a methodological strategy (disaggregation) is a richer understanding of the complexity of identity, as is demonstrated in the research reviewed next.

For research specifically addressing barriers to seeking treatment for Korean-American undergraduate students, findings suggest that women reported significantly higher cultural congruity (individual's self-reported identity matches with his or her environment's culture) and more positive help-seeking attitudes than Korean men (Gloria et al., 2008). However, researchers suggest that adherence to Asian (Korean) values were associated with decreased help-seeking attitudes for women and second generation participants only. This first finding contradicts previous research findings that higher cultural congruity or lower levels of acculturation predicted lower rates of formal mental health treatment-seeking. However, this study suggests that it is not primarily adherence to cultural values that regulates an individual's likelihood to seek psychological treatment, but generational, gender, and acculturation influences that also play a role in Korean American undergraduates' help-seeking attitudes. Such findings shed light on the complexities and intersectionalities of help-seeking that are often obscured by simplistic racial/ethnic categorizations.

Another study that disaggregated Asian populations into specific ethnicities was conducted by Suan and Tyler (1990) on Japanese-American college students. In a sample of 90

Japanese-American students and 91 Caucasian-American students, researchers investigated Japanese-Americans' underuse of mental health resources as a function of attitudes about the nature of mental health (mental health values) and preference in type of help-seeking for personal problems. These researchers concluded that Japanese-American participants were less likely than Caucasian Americans to rank mental health professionals as their first choice for assistance with serious interpersonal/emotional problems and were more likely to seek help from close friends. For example, researchers analyzed participants' ranking in types of help-seeking behavior (i.e., physician, clergyman, close friend or friends, and self-referral for formal psychological treatment) and found that Japanese subjects were significantly less likely to refer someone to a mental health professional for marital problems compared to Caucasian subjects. Also, Japanese participants were more likely than Caucasians from the U.S. to rate their own friends as the first choice of referral for a vignette describing someone experiencing auditory hallucinations or a separate vignette describing someone engaging in hostile, violent behavior (Suan & Tyler, 1990). Despite the researchers' disaggregation and focus on Japanese Americans, a significant limitation to this study was it did not account for possible generational factors that could have influenced participants' rankings of forms of help-seeking treatment. Ethnic and generational influences need to be accounted for in future research and these implications are discussed below.

Research conducted on immigration influences such as acculturation also has mixed findings. Srinivasan and Guillermo (2000) suggested that there are variations in the level of adjustment among first-generation and third-generation Japanese and Chinese and among highly educated Asian Indians, Chinese, and Koreans as compared with less acculturated Hmong and Laotians. This heterogeneity in acculturation and immigration status, as well as phase of

adjustment to the US are powerful explanatory variables in understanding differences in seeking assistance for health and mental health care needs.

Similarly, Abe-Kim et. al (2007) found that there are important differences in service use between immigrants and US-born individuals. For example, use of services differed according to nativity status such that US-born individuals used mental health services at higher rates than Asians who immigrated to the United States. Also, second-generation individuals (children of immigrants) were more similar to immigrants in their use of services compared to third-generation individuals. These findings support a generational rather than ethno-racial approach to classification of respondents. Researchers also found that US-born Asian Americans, particularly third-generation or later, gave higher ratings than 1st and 2nd generation Asian Americans on helpfulness and level of satisfaction with any form of service utilization for formal psychological and medical services (Abe-Kim et. al, 2007). Specifically, more than 90% of Filipinos reported higher rates of satisfaction as a result of seeking professional psychological help at post-treatment than other ethnic groups in the study (Chinese=72.1%; Vietnamese=74.9%; other Asian=88.1%). Other researchers replicated the results of this study, suggesting that US-born Asian Americans may be more likely to use mental health services than Asian who have immigrated to the United States (Kung, 2003 & 2004; Young, 1998).

Relative levels of acculturation have also been identified as barriers to seeking psychological treatment for Asians and Asian Americans. Specifically, Sodowsky, Kwan, and Pannu (1995) suggested people of Asian or Pacific Islander ancestry living in the United States may identify along two orthogonal dimensions: enculturation to their traditional ethnic heritage and acculturation to the values of the dominant culture.

A salient example of the effects of these dimensions is found in research by Chun and Akutsu (2009). These researchers suggest that when families follow customary or familiar interaction patterns that are no longer effective in a new cultural environment they can enter a state of "homeostasis" in which they essentially become "stuck" during their acculturation process. If new or modified communication patterns are not established, then homeostasis and the subsequent acculturative stress arise in the parent-child subsystem. According to structural family therapy, family members form distinct groupings or subsystems based on characteristic patterns of family interactions. Asian American families exhibit a range of subsystems in multigenerational households, each with its own culture-specific family roles and expectations for behavior, reflecting their cultural values and beliefs, social orientation, and socioeconomic needs and resources. According to the findings of Chun and Akutsu (2009), acculturation stress generally increases risk for depressive and anxiety symptoms. However, in general, social support, younger age, and knowledge of the United States prior to immigration improve an individual's resiliency to psychological distress. Specifically, the acculturation experiences of Asian American family members can thus be entwined- the nature and rate of acculturation of one member can potentially affect the acculturation experiences of other members. The extent to which Asian American family members expand or transform the ways in which they relate to one another in a new cultural environment can also affect their collective experience of acculturation. It is a recursive, mutually influential system in which the family members co-create their experience of adjustment to the dominant culture.

Atkinson et al. (1990) also suggested that lower acculturation is associated with a higher preference for discussing personal problems with help providers. According to Sue & Sue (2003), dominant American culture promotes future time orientation-- evidenced by its emphasis

on youth and achievement, controlling one's destiny- planning for the future, and maintaining an optimistic and hopeful future outlook. This future time orientation poses a challenge to Asian American families who follow a "past-present" orientation that links family history and reverence for the past (viz., respecting family ancestors) with their present day lives and activities, and treats age as a marker of wisdom, respectability, and authority. Asian American families may experience acculturation stress when attempting to reconcile these two conflicting time orientations.

Furthermore, lower levels of acculturation have been linked with increased likelihood to seek out other forms of healing or help-seeking (Solberg, Choi, Ritsma, & Jolly, 1994). For example, Asian American college students with lower levels of acculturation may prefer to seek help for personal problems through informal and non-professional members such as community elders, religious leaders, student organizations, and church groups (Solberg, Choi, Ritsma, & Jolly, 1994). In a study by Atkinson, Kim, and Caldwell (1998) Asians found traditional Western counseling approaches to be among the least helpful alternatives for many Asian American college students. Thus, the needs of less acculturated Asian Americans may be vastly different from the skills and approaches of traditional Western psychotherapy. Furthermore, client-therapist match or clients' perceptions of dissimilarity between themselves and counselors regarding worldview and mental health beliefs has been associated with more unfavorable ratings of the counselor (Atkinson et al., 1991), less willingness to see the counselor (Atkinson, Wampold, et al., 1998), and less favorable counseling outcomes (Fischer, Jome, Atkinson, Frank, & Frank, 1998). Mallinckrodt, Shigeoka, and Suzuki (2005) also suggest that Asian Americans with higher levels of acculturation (i.e., identification with the dominant culture) are associated with greater willingness to seek Western-style counseling.

Such patterns of findings indicate that any consideration of Asian immigrant and Asian American help-seeking behaviors must be understood as being more complex than simply seeking or non-seeking behaviors. The research reviewed indicates that this cohort does seek out assistance for mental health but that acculturation differences affect their choice of provider (community based vs. professional).

Exosystem

Exosystem influence will now be discussed as a possible barrier to seeking formal psychological help. These influences include culture, stigma and shame associated with mental health service seeking.

A systemic approach to understanding Asian Americans likelihood to utilize formal psychological help is appropriate for several reasons. Collectivistic cultures place more importance on interpersonal success, social cohesion, and social support when compared to individualistic cultures which emphasize individual achievement, independence, and autonomy (Kitayama & Markus, 1998). Triandis, McCusker, and Hui (1990) studied the cultural differences in conceptualizations of self. In their study on Chinese immigrants and Chinese Americans, participants were instructed to complete 20 statements that began with "I am." Results from this study suggest that Chinese participants were almost three times more likely than Americans to give a collective response (i.e., identifying themselves in terms of group membership) compared to Caucasian Americans. The authors proposed that this phenomenon occurs in collectivist cultures because self/other boundaries are weak and individuals might experience self-related emotions as a consequence of another's deed more intensely compared to people from an individualistic culture.

Henkin (1985) also noted that in traditional Japanese culture, greater emphasis is placed on self-discipline, concealment of personal frustrations, and subjugation of individual concerns to the needs of the group. Asian American cultures are organized around one's conduct of interpersonal relationships, so it is crucial to understand how such relationship factors may influence individuals' utilization of formal mental health services. Centralizing the

individualistic-collectivistic concept in our discussion of help-seeking is a core initiative in any discussion of current treatment and research practices.

Sue et al. (1999) assert that psychologists must recognize that psychological concepts and theories have been developed from a predominantly Euro-American context and may be limited in its applicability to people from different historical and ethno-cultural traditions. Maintaining the current paradigm's approach to treating people from collectivist backgrounds through the present individualistic perspective will not improve the disparity of professional service utilization by Asian Americans.

Reviews of the research and theory psychological help-seeking have shown mixed results regarding the influence of culture on individuals' likelihood to seek psychological services. For example, Brickman et al.'s (1982) Theoretical Framework of Responsibility Attributions proposes four attribution models by which individuals hold themselves responsible for causing and solving their problems: the *moral model*, *compensatory model*, *enlightenment model*, and *medical model*. In the moral model, individuals hold themselves responsible for the cause and solution of their problems. In the *compensatory model,* individuals believe internal factors are responsible for the solution, but external factors are responsible for the cause of their problems. By contrast, individuals in the *enlightenment model* attribute responsibility for the solution to external factors but the cause to internal factors. Finally, individuals in the *medical model* believe external factors are responsible for both the cause and solution of their problems. Results from this study suggest Asian Americans who strongly adhere to Asian values were more likely to attribute the cause of depression to internal factors, which in turn made them more likely to prefer disengagement coping strategies and less likely to prefer engagement strategies. This is important in understanding Asian Americans' use of mental health services because they are less

likely to seek out services or help because these individuals believe that they are the source of their problems and suffering. Consequently, it is more of an internal struggle to solve their problem.

This idea is supported by Umemoto (2004), suggesting that Asian American university students who conceptualized mental illness as controllable were likely to prefer self-help methods for dealing with psychological difficulties instead of seeking professional psychological help.

Kim, Sherman, and Taylor (2008) also suggested that Asian Americans have been shown to rely less on social support in general. This finding contradicts previous research that suggests that Asian Americans are more likely to utilize informal means of help-seeking such as church groups, religious leaders, and student organizations for support as a function of lower levels of acculturation (Solberg et al., 1994). Also this population tends to utilize problem avoidance and social withdrawal as its primary means to cope with stress more so than European Americans (Chang, 2001). Therefore, Asian Americans who strongly adhere to Asian values were more likely to prefer disengagement coping strategies for symptoms of depression (Wong, Kim, & Tran, 2010). However, this choice has important clinical implications. Although the use of passive coping strategies is not inherently maladaptive, it might lead Asian Americans to deny their need for help and delay seeking professional services when faced with mental illnesses (Kung, 2004).

The differences in values of Asian cultures and traditional Western counseling approaches may decrease an individual's likelihood to seek professional mental health treatment (Sue, 1994). For example, counselors in university settings frequently consider family conflict and issues of separation as the cause of client's presenting problems and as a result, expect their

clients to disclose dissatisfaction about family relationships. This exemplifies the Western or individualistic culture's influence on traditional psychotherapy. Disclosing such information for a person who maintains Asian cultural values would be extremely difficult according to Mallinckrodt, Shigeoka, and Suzuki (2005). They believe that this would be difficult for people who embrace Asian values because disclosing information about their family runs counter to the practices of Asian Americans, who prize family harmony, conformity to expectations, emotional self-control, collective identity, and the esteem in which one's family is held in the community. This highlights an important difference when working therapeutically with Asian American clients. Despite the presence of family conflict, the cultural value of group harmony and maintaining interpersonal relationships trumps an individual's reasoning to report distress.

Cultural factors such as stigma and shame have been considered as barriers to seeking professional psychological help for Asian Americans. Abe-Kim et al. (2007) suggested that stigma or loss of face may act as constraints on service use. For example, Takeuchi, Leaf, and Kuo (1988) found the shame of admitting and seeking mental health treatment for alcohol and emotional issues to be a major barrier to seeking mental health treatment for those of Filipino, Japanese, and Native Hawaiian ethnicity. These findings are supported by previous research by Lin et al. (1978) where in Chinese Americans delayed referrals to a community mental health agency because of the stigma associated with admittance of personal problems, seen as flaws for which individuals need to seek mental health services.

The US Surgeon General as well highlighted the immense influence of stigma on mental health service utilization (USDHHS, 1999). Stigma associated with the field of mental health service was described as the most "formidable obstacle" in preventing the progress of the mental health field for all potential clients. Moreover, this stigma and negative public attitudes about

mental illness may be even more powerful for racial and ethnic minorities (USDHHS, 2001). Specifically, among Asian Americans, the tendency to avoid help-seeking may arise from dual concerns: individual stigmatization and the collectivistic notion of shaming one's family (Uba, 1994). Ting and Hwang (2009) address the "dual stigma" experience of Asian Americans and applied Anderson's Sociobehavioral Model (SBM; 1995) to their findings. This model for help-seeking behaviors suggests that health service utilization is determined by the combination of environmental factors (e.g., location of services and type of services available) and population characteristics (i.e., characteristics specific to each individual). In a sample of Asian American college students, researchers found that stigma tolerance may be a more direct measure of the degree to which an individual subscribes to the cultural attitudes regarding mental health problems and service use. Stigma tolerance was strongly related with help-seeking attitudes (Ting & Hwang, 2009). These findings support Uba's (1994) hypothesis that an individual's behaviors (both positive and negative) reflect upon his or her entire family. Therefore it may be particularly difficult for Asian Americans to tolerate being stigmatized because their personal stigma affects the reputation and status of their family members as well.

Mesosystem

The mesosystem includes family dynamics, structure, and environmental factors that influence individuals' decisions to seek formal psychological help. A common theme in research is that there is a relationship between Asian and Asian American's family dynamics and structure that influences use of formal psychological services. However, results have been decidedly mixed. For example, family conflict predicted both mental health and medical health use for U.S. born Chinese Americans, but family support was not predictive of help-seeking (Abe-Kim, Takeuchi, & Hwang, 2002).

Similarly, Abe-Kim, Takeuchi, and Hwang (2002) found that family conflict [based on a participant's score on the University of Michigan's Composite International Diagnostic Interview Positive and Negative Social Interactions Scale; Kessler et al., 1994] was the strongest predictor of help-seeking only for medical services. Family conflict was did not significantly predict Chinese and Chinese Americans' likelihood to use professional psychological services. Also, low levels of family support were not associated with help-seeking for either medical or psychological services in this ethnic group. These results suggest that it was the *presence of family conflict* that precipitated help-seeking more than the *absence of supportive relationships* between family members. Such findings echo those found for exosystem influence. Asian and Asian American collectivistic cultures emphasize interpersonal relationships and group harmony and consequently, may underlie individual motivations to seek psychological services.

Social influences related to help-seeking among Asian Americans have also been posited to have negative influences on professional psychological service usage. For example, Araneta (1993) suggested that Asian Americans tend to discourage family members from seeking mental health services because of profound shame associated with seeking assistance outside of the

family or in-group. Similarly, Kim and Park (2009) examined help-seeking beliefs, attitudes, and intent among Asian American college students using a multiple mediation model to determine if the relationship between Asian values and willingness to see a counselor was mediated by attitudes toward seeking professional psychological help and subjective group norms. The researchers defined subjective norm as the "person's perception of the social pressures put on him to perform or not perform the behavior in question" (Ajzen & Fishbein, 1980, p. 6) and normative beliefs as "beliefs that specific individuals or groups think he should or should not perform the behavior" (Ajzen & Fishbein, 1980, p. 7). The results of the Kim and Park (2009) investigation indicated that such subjective norms significantly mediated the effect of Asian values on willingness to see a counselor. These findings demonstrate the importance of social influences, especially those of family and extended family in collectivist cultures, as a mechanism that explains the link between Asian values and the intent to seek (or not seek) counseling (Kim & Park, 2009). Furthermore, these results are consistent with the literature on help-seeking outside the family for mental health issues which may be perceived as bringing shame to the family (Root, 1993; Yeh, 2000) and to the larger ethnic community (Yang et al., 2008).

The stigma and shame associated with mental health utilization has also been studied. According to Masuda et al. (2009), in the mental health field, stigmatizing attitudes are often directed toward people who are labeled as having a psychological disorder and toward people seeking help. Researchers defined stigma toward those diagnosed with a psychological disorder as a multi-dimensional negative attitude toward a group of people who are construed to be lacking appropriate skills or abilities. As a result, such stigmatized individuals are viewed by others as incompetent, unpredictable or threatening (Kurzban & Leary, 2001). Furthermore,

stigmatizing attitudes toward seeking professional psychological services may be construed as multi-dimensional negative attitudes toward help-seeking as a sign of personal failure or weakness (Fischer & Turner, 1970). Research supports the notion that those who endorse stigmatizing attitudes toward people with psychological disorders are less likely to have favorable attitudes toward seeking professional psychological help themselves (Leong & Zachar, 1999; Vogel et al., 2005). Among ethnic minorities such as Asian immigrants and Asian Americans, the literature suggests that these individuals tend to view seeking professional psychological services for their own struggles as a sign of weakness and bringing shame to the family (Root, 1985).

As previously mentioned, Asian cultures' emphasis on family hierarchy, emotional restraint, avoidance of shame, and saving "face" (Flaskerud, & Liu, 1990; Uba, 1994; Zane & Yeh, 2002), are in contrast to Western norms of counseling such as self-disclosure and emotional expressiveness (Sue & Sue, 2003). Traditionally, Asian Americans are expected to deal with problems by themselves or take them to the family. If left unresolved, individuals might turn to churches, physicians, elders, or clan and other ethnic organizations (Inman & Yeh, 2006). Non-kin intervention such as seeking professional psychological help is often considered shameful and a violation of the family hierarchy (Sue, 1994) and my bring disgrace to the family as a result of seeking outside help may indicate inadequacy on the part of familial support (Root, 1985). Shea and Yeh (2008) investigated the interrelationship between adherence to Asian values, stigma from seeking psychological help, relational-interdependent self-construal, age, and gender for Asian American college and graduate students. Lower adherence to Asian values, lower levels of stigma, and a higher relational-interdependent self-construal were associated with more positive help-seeking attitudes. Also, female and older students possessed more positive

help-seeking attitudes. These results are consistent with previous studies wherein Asian American students with a higher level of perceived stigma for receiving psychological help tended to have negative help-seeking attitudes. Asians may perceive receiving professional psychological help as a sign of weakness (Narikiyo & Kameoka, 1992), personal immaturity (Uba, 1994), or an indicator of heredity flaws that shame the family (Flaskerud & Liu, 1990; Yeh, 2000).

The complexities of acculturation are also evident in recent research. Lee et al. (2009) found stigma and shame to be consistent barriers to seeking mental health treatment in a sample of 1.5 and 2nd generation Asian American young adults (primarily of Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, and Vietnamese ethnicities). Researchers defined 1.5 generation as immigrants who came to the US before age 16 and 2nd generation as people who were born in the US. Among this population, researchers found several stressors to be predictive of seeking mental health treatment, pressure to meet parental expectations of high academic achievement and live up to the "model minority" stereotype; difficulty balancing two different cultures and communicating with parents; family obligations based on the strong family values, and discrimination or isolation due to racial or cultural background. Among this specific population, young Asian immigrant and U.S. born Asian Americans tend not to seek professional help for their mental health problems and instead, use personal support networks such as close friends, significant others, and religious communities for support. This supports Solberg et al.'s (1994) findings that people with lower levels of acculturation may prefer to seek help from informal or non-professional sources. This suggests that a combination of factors is likely to influence Asians and Asian Americans' motives to use mental health treatment, including the shame and stigma associated with seeking help from non-kin (or in-group) members.

Furthermore, Masuda et al. (2009) found that (when compared to European American participants) Asian American participants showed greater stigmatizing attitudes toward people with psychological disorders (e.g., greater anxiety related to people diagnosed with a psychological disorder, greater perceived relationship difficulties with people with a psychological disorder), and lower stigma tolerance with regard to professional psychological help-seeking. In addition, Asian American participants had less confidence in psychological professionals than non-Hispanic Caucasians and African Americans (Masuda et al., 2009). The findings of this study are instructive for any critique of understanding decreased service use among Asian American populations.

Yang, Phelan, and Link (2008) suggested that communal shame related to using Western forms of mental health treatment among Chinese Americans was a major barrier for seeking professional psychological services. This (indicates) that perceived societal influences (i.e., communal shame) may mediate help-seeking. However, the impact of social norms on help-seeking attitudes and behavior among Asian Americans remains a largely under-investigated phenomenon.

People from collectivist cultures are more likely to associate individual success and failures as reflections upon their greater group (i.e., family). Stipek (1998) studied this phenomenon and suggested that experiences of achievement or transgression by a closely related person might engender more intense feelings of pride or shame in Chinese persons compared to Caucasian Americans. Furthermore, with regard to transgressions, Chinese participants agreed more than Americans with statements suggesting that individuals should feel ashamed for behavior or outcomes related to family members (Stipek, 1998).

Liao et. al. (2005) studied self-concealment and its influence on participants' attitudes toward seeking professional psychological services. Researchers defined self-concealment in this study as the tendency to hide distressing and potentially embarrassing personal information. The results of this study suggest that self-concealment may be more negatively related to attitudes toward seeking professional psychological services for Asian immigrants and Asian American participants than for Caucasian Americans.

In light of Asian Americans underutilization of traditional mental health services, T. Chang and R. Chang (2004) proposed using the Internet to capture this specific audience in terms of seeking mental health services. The authors hypothesized using online services (i.e., online support groups, online counseling, and mental health informational sites) would potentially increase accessibility as well as decrease feelings shame and stigma. The authors propose that online psychological services would decrease the shame associated with seeking mental health services for personal problems and consequently, decrease the stigma of "weakness" associated with people who seek these services. Chang and Chang (2004) found that both Asian American and Asian national students had more significantly more positive attitudes toward seeking traditional face-to-face help than toward seeking online help. They concluded that assimilation into American culture was not a significant predictor of attitudes towards online help-seeking. This finding contradicts past research which demonstrated that assimilation into American culture is related to more positive attitudes toward seeking help for traditional face-to-face counseling for both Asian American (Abe-Kim et. al., 2007; Atkinson & Gim, 1989; Srinivasan & Guillermo, 2000; Tata & Leong, 1994) and Asian national college students (Zhang, 2000).

Microsystem

The microsystem encompasses the individual's gender and age. A consensus among researchers is that females tend to have more favorable attitudes toward seeking professional psychological services than males regardless of culture (Fischer & Farina, 1995; Masuda et al., 2005) and seek psychological services for emotional issues more frequently than males (Moller-Leimkuhler, 2002; Rabinowitz et al., 1999).

Research on aggregated Asian American populations suggests that Asian females tend to have more positive attitudes toward seeking professional help than do Asian males (Gim et al., 1990; Gloria, Hird, & Navarro, 2001; Leong & Zachar, 1999; Tata & Leong, 1994; Tracey, Leong, & Glidden, 1986; Yeh, 2002; Yoo, Goh, & Yoon; 2005). This finding may be due to expectations and processes surrounding counseling and disclosure of emotions that are more congruent for Asian females. In comparison, Asian males are expected to be emotionally restricted, logical, and counter-dependent based on cultural and societal norms (Chang, Yeh, & Krumboltz, 2001). For example, Asian men learn at a young age to not express emotions in the presence of others and to be responsible for maintaining the family name and reputation. Therefore, seeking psychological services may reflect poorly upon Asian American males as well as on their families (Sue, 1994). Similarly, Good et al. (1989) assert that a traditional male gender role (e.g., provider, protector) influences males attitudes toward seeking psychological help due to patterns of avoiding or ignoring sources of professional help. Researchers suggested that "as men's values regarding the male role became less traditional, their view of psychological help-seeking became more positive" (Good et al.; 1989, p. 209). Good et al. assert that as gender norms decrease for Asian American males, their attitudes toward seeking psychological help became more favorable.

The data to support these assumptions are mixed. Abe-Kim (2007) did not find a significant relationship between age at the time of immigration and seeking formal psychological help. Also, the number of years in the US and English language proficiency were not associated with service use (Abe-Kim, 2007). Similarly, Masuda et al. (2009) and Solberg et al. (1994) found no significant interaction between ethnicity and gender. Specifically, women of Asian ancestry were not more likely than men of Asian ancestry to have positive attitudes toward seeking professional psychological help.

The literature on age and its influence on service utilization are also mixed. Shea and Yeh (2008), utilizing an aggregated sample of Asian American college students, found that older students have more positive help-seeking attitudes. One explanation for these positive help-seeking attitudes is that older students may be more knowledgeable about the types of mental health resources available and they may have developed coping strategies including the ability to seek professional psychological help. Another explanation is that older students are more independent from their parents and immediate families, so they cannot go to them for assistance as they did when they were younger and had more interactions. The idea that generational influence may be motivating participants' positive help-seeking attitudes in conjunction with age should be addressed in future research.

PROPOSED THEORETICAL MODEL

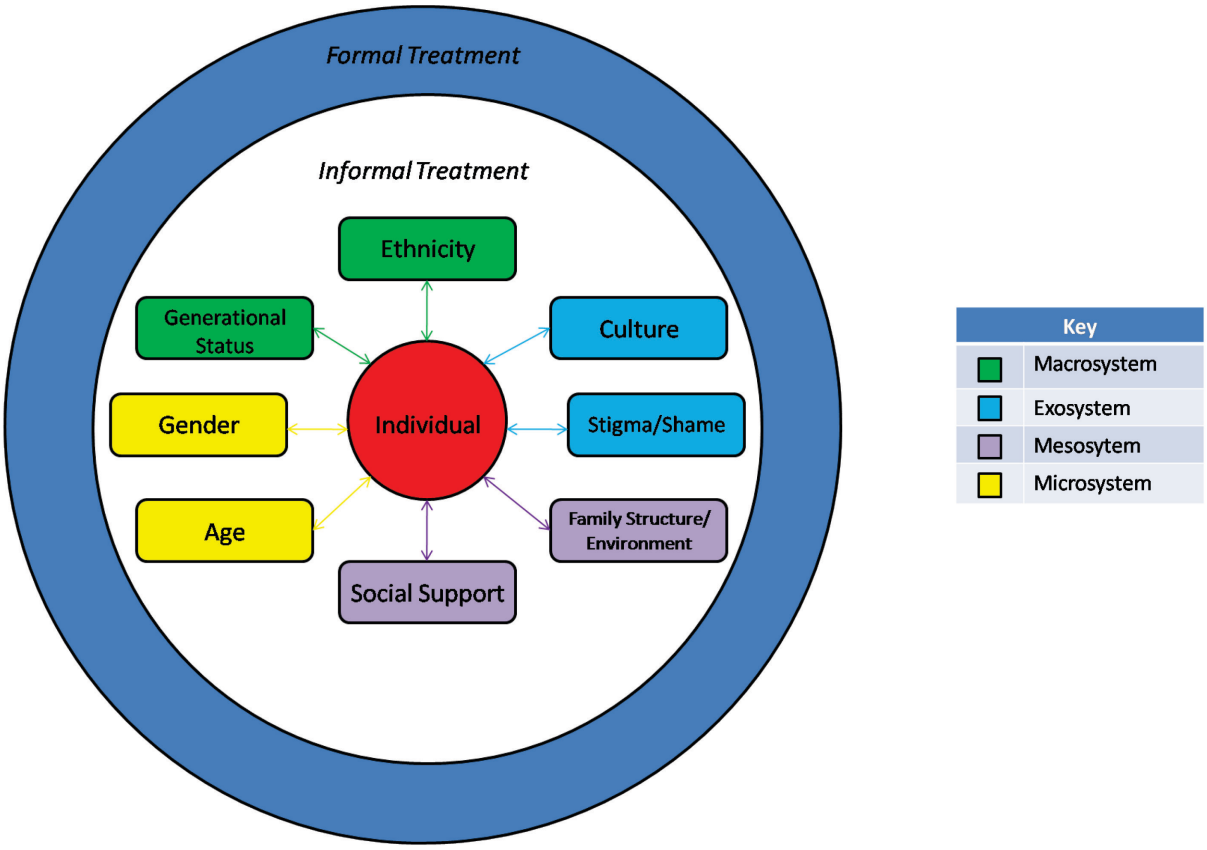
There is a pressing need for future research to apply a systemic model to Asian immigrants and Asian Americans' mental health help-seeking behaviors. Bronfenbrenner's Ecological Systems Theory (1992) was applied throughout this review to emphasize the importance of taking a global perspective to understand the factors that influence this population's likelihood to seek professional psychological treatment. This systemic approach to understanding help-seeking has been advantageous to understanding treatment seeking (Abe-Kim, et al., 2002; Hall & Okazaki, 2002; Sue, et al., 1999; Sue & Terry, 2005).

The proposed model to understanding help-seeking behaviors of Asian immigrants and Asian Americans is best understood through a path analysis model (see Figure 1). Based on previous research findings, I propose eight factors that influence an individual's likelihood to seek professional psychological treatment; ethnicity, generational influence (acculturation), culture, stigma/shame associated with mental health, family structure/environment, social support, gender, and age.

The proposed model is organized in a manner such that the less one is influenced by each of these eight aforementioned factors the more likely he/she is to seek formal, professional psychological help. Conversely, the more the individual is entrenched with the eight factors, the less likely he/she is to seek professional psychological help. Further, he/she may be more willing to seek out informal forms of help-seeking including; religious healers, peer support groups, family members, friends, etc. It is important that the application of this model is utilized fully. Previous researchers have approached help-seeking by only addressing two or three variables included in this proposed model to understanding help-seeking. Furthermore, a path analytic model affords a more intersectional analysis of the recursive and interdependent influences on

Asian immigrants and Asian Americans' formal help-seeking behaviors. This allows researchers to understand help-seeking behaviors from a systemic point of view, which may be most applicable to this population.

Figure 1. Proposed Help-Seeking Model



IMPLICATIONS FOR CLINICAL RESEARCH, EDUCATION, & PRACTICE

As a result of the evolving demographics of the United States, the field of clinical psychology must make substantive revisions in its training, research, and practice (Hall, 1997). Hall states, "without these revisions, clinicians will risk professional, ethical, and economic problems because psychology will no longer be a viable professional resource to the majority of the U.S. population" (p. 642).

I will now discuss these implications and make suggestions for future directions for the field of clinical psychology by highlighting themes among past researchers' suggestions for research, education/training, and practice as well as providing first-hand experience as a Japanese-American graduate student.

Implications for Clinical Research

Despite the increased number of published articles on Asian immigrants and Asian Americans in the past two decades, a lack of knowledge is still present. A major reason for the gap between research and practicing psychology is the decreased ability to generalize research findings to the consumers (i.e., patients). Many researchers fail to disaggregate the ethnic groups within their sample and need to identify specific moderating variables such as gender, ethnicity, generational status, etc. Data need to be aggregated so clinicians are better able to apply empirically supported treatments (ESTs) to the appropriate populations. For example, it was not until the 2000 Census that The Office of Management and Budget (OMB) defined Asian as "A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. This includes 'Asian Indian,' 'Chinese,' 'Filipino,' 'Korean,' 'Japanese,' 'Vietnamese,' and 'Other Asian'" and disaggregated Asian and Pacific Islander/Native Hawaiian (U.S. DHHS, 2001). This lack of clarity in the Census's codifications of ethnic/racial groups can and does lead to the problems with interpretation and variance in efficacy of treatment modalities outlined above.

It would be optimal to evaluate a mental health program or intervention based on its effectiveness in specific subpopulations or disaggregated ethnicities (Hall, 2001; Ida & Ja, 2007). However, researcher preferences for particular statistical analytical strategies are thwarted by the small number of subjects within each group (Ida & Ja, 2007). Also, a major limitation noted by Hall (2001) is the simple inclusion of Asian Americans as a pan-ethnic entity and not accounting for known sources of psychological variation: acculturation, language, education, socioeconomic status, culture, and the experience of discrimination. This is a problem because

participants who identify themselves "Asian American" are vastly different than first-generation Asian immigrants. Also, it is possible that these acculturated ethnic minority persons are more likely to participate in psychological research because of their mainstream identification and resources.

Researchers should also address culturally appropriate interventions in future research. Assessing for cultural and linguistic appropriateness of mental health services is essential for research and evaluation (Ida & Ja, 2007). For example, a patient's unwillingness to engage in therapy may be viewed as a lack of motivation in a Western psychological context. However, researchers and clinicians must be mindful of the patient's culture and design culturally appropriate assessments and interventions to determine whether a particular behavior is linked to particular psychological factors or is an expression of the individual's culture. Furthermore, assessment and measurement tools are often based on specific Western concepts that have few or no parallels with some Asian cultures (Sue, 1994; Hall, 1997; Ida & Ja, 2007). Therefore, appropriate measures need to be developed using disaggregated populations based on specific cultures because different cultures may express behavioral manifestations of similar psychological constructs differently.

Further, research also needs to be conducted on the efficacy of empirically supported therapies (ESTs) and culturally sensitive therapy (CST). Empirically supported therapies are treatments that have been demonstrated to be superior in efficacy to a placebo or another treatment (Chambless & Hollon, 1998). The criteria for well-established treatments are at least two between-groups design experiments or 10 or more single-case design experiments by at least two different investigators demonstrating superiority to a pill, psychological placebo, another treatment, or equivalence to an already established treatment. In addition, treatment manuals are

required in the experiments and client characteristics must be clearly specified. On the other hand, culturally sensitive therapies may involve tailoring of psychotherapy to specific cultural contexts: persons from one cultural group may require a form of psychotherapy that differs from psychotherapy for another cultural group (Hall, 2001). However, within the current paradigm of clinical psychology their exists a strong push for either CSTs or ESTs. Advocates of ESTs consider their methods to be universally valid and may simply apply ESTs to diverse populations despite research testing its efficacy with a sample of European Americans. Conversely, CSTs argue that simply implementing a model from one cultural group to another is inadequate. Yet, there is no more support for CSTs than there is for the efficacy of ESTs with ethnic minority populations (Hall, 2001).

Sue (1999) suggests that the scientific aspirations of psychology are itself, the culprit for this lack of psychological research on ethnic minority populations. He argued that the field is left in a position wherein researchers value the internal validity in studies and to practitioners focus on the external validity or generalizability of therapies. Clinicians however cannot wait until psychotherapies for ethnic minorities are empirically validated. Hall (2001) recommends that both clinicians and researchers modify ESTs that have been developed with nonminority populations to become CSTs. This collaborative approach between proponents of ESTs and CSTs may be the best intervention for clinical psychology for now.

Implications Clinical Education & Training

Mental health professionals have an ethical obligation to be educated and sensitive to the needs of an increasingly diverse clientele. Typically, the historical/political binary of black-and-white relations have been privileged in psychological research and the majority of the research has focused exclusively on those populations (Mok, 1998). Practitioners however are ethically obligated to sensitize themselves to the backgrounds and lifestyles of all ethnic minorities in the US.

Beginning clinicians also need to be willing to examine their own stereotypes or perceptions of minorities (i.e., Asian Americans). Based on my clinical experiences thus far, a major aspect of becoming a culturally sensitive therapist is to acknowledge your own individuals biases and assumptions. Simply noticing these biases and assumptions however is not sufficient to be a sensitive therapist. Psychoeducation, training, and offering culturally specific courses are imperative for preparation to work with diverse clients (Buhrke & Douce, 1991). The goal of graduate courses in clinical psychology should be similar to that of other psychology courses and practica: to teach mental health professionals how to be good psychologists in terms of analyzing problems, deciding on alternatives, seeking consultation, and minimizing negative consequences.

The addition of continuing-education (CE) requirements is also helpful in training culturally sensitive clinicians. Throughout the history of psychology, many psychology programs ignored and failed to teach students about diversity until 1991, when the APA emphasized the importance of multicultural counseling (Pedersen, 1991). Despite small systemic changes to the academic and training experiences of those in clinical psychology, few actions have been undertaken to enforce this paradigm shift as it relates to clinical standards, professional accreditation, and minority representation in publications (Hall, 1997).

Hall (1997) also suggests that the inclusion of diverse faculty and students in clinical psychology programs is paramount for training culturally sensitive clinicians. Having diverse faculty members (i.e., ethnic, religious, gender, socioeconomic status, sexual orientation, etc.) as experts, role models, researchers, advisors, and colleagues is essential. Bernal and Castro (1994) found clinical programs with more ethnically diverse minority faculty offered more minority courses, conducted minority research, and had directors of clinical training who felt multicultural practitioner training is important. However, forty-eight percent of the clinical psychology programs at the time of the study had no ethnic minority faculty, thirty-seven percent of programs had one ethnic minority faculty member, and eighteen percent of graduate programs in the U.S. had two or more minority faculty members (Bernal & Castro, 1994). This study highlights the need to increase diverse faculty and students in clinical psychology programs. It should be noted that simple inclusion of diverse individuals in programs is not the cure. Clinical psychology graduate programs must utilize these individuals' expertise and provide them with support needed to retain minority faculty and students in the program.

Implications for Clinical Practice

Practicing psychologists are ethnically responsible for providing culturally sensitive psychotherapy (APA, 2002). A major component of providing culturally respective therapy stems from knowledge of diverse backgrounds. Clinicians must be mindful of the client's unique ethnic, cultural, generational status, family support/influence, socioeconomic status, etc. and how these factors influence the client's presenting problems. Failure to do so and assuming that the client's presenting problems is the result of only cultural influences may be maladaptive. Casas (1984) used the term *cultural overgeneralizations* when mental health practitioners assume that all presenting problems are related to the client's culture rather than to other factors. These errors will lead to the continued increased in underutilization of psychological services by ethnic minority populations (Hall, 1997) and stagnation of the field of clinical psychology.

Research has shown that ethnic clients underutilize mental health facilities at lower rates compared to Caucasian clients (Root, 1985; Padilla, Ruiz, & Alvarez, 1975; Sue, McKinney, & Allen, 1976; Sue, McKinney, Allen, & Hall, 1974). Of the minority clients who receive psychological services, individuals who seek formal psychological help tend to terminate counseling or therapy at a higher rate than do Caucasian clients (cf. D.W. Sue & Sue, 1990). This underutilization and premature termination may result from ethnic clients distrusting psychologist, feeling that therapist are insensitive to the issues they confront as minorities, and perceiving that services are not responsive to their needs (Bloombaun, Yamamoto, & James, 1968; Nickerson, Helms, & Terrell, 1994; Sue, 1988). If services do not change, the field of clinical psychology may become "culturally obsolete" (Hall, 1997) due to the field's inadequacy to fulfill the needs of the growing ethnic minority population of this nation.

Moreover, a motivating factor for clinical psychologists to practice culturally sensitive psychotherapy is the "Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2002). These general guidelines were developed to help practitioners work with diverse clients and improve clinical practice with diverse populations. Specifically, the APA offers the following guidelines to psychologists working with diverse populations:

1. Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.
2. Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.
3. As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.
4. Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.
5. Psychologists strive to apply culturally-appropriate skills in clinical and other applied psychological practices.
6. Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices.

Applying these guidelines while working with diverse clients is part of the solution. Root (1985) suggests working from a systems framework with sensitivity to the individuals' cultural and familial rules regardless of if the treatment is for an individual, couple, or family. While working with individuals from a collectivistic culture, as is found in many Asian countries (Kitayama & Markus, 1998), presenting problems need to be understood, diagnosed, and treated with knowledge of the cultural context of the person presenting for help (Root, 1985). Service providers also need to have an understanding of cultural proscriptions for the types of symptoms one is likely to manifest given their cultural background. For example, a first generation Japanese immigrant may present with entirely different presenting problems or concerns during psychotherapy intake as compared to a more acculturated fourth generation Japanese American. Clinicians should therefore be trained and educated about different aggregated populations and the influences of gender, generational status, socioeconomic status, etc. on client's presenting problems (Kleinman et al., 1978).

Furthermore, understanding one specific ethnic group (i.e., Chinese families) will not automatically mean that one will understand Filipino or Japanese families (Root, 1985). Therapy with Asian Americans does not require that therapists develop entirely new skills. The skills necessary for being an effective therapist, however, remain the same such as active listening, communication, empathy, and formulating treatment goals. Root (1985) emphasizes what may be new to the therapist is consideration of the context within which the problem exists and the service provider needs to be willing to acknowledge his or her prejudices, biases, and definitions of healthy psychological functioning. Root (1985) offers five guidelines for facilitating the initial therapeutic contact with diverse clients: (a) the client's beliefs are about mental and emotional problems are important, (b) most clients, because of their cultural context and relationships with

other helping systems will expect the therapist to be an authority and tell them what they have to do in order to feel better, (c) many clients will come into therapy hoping to be able to leave with an answer and will look to concrete methods of problem solving, (d) as in any therapy, it is important to determine the limits in helping the family and how to become a part of the system, and (e) anticipate reasons for which the client or family would not come back for a second appointment and attempt to address these concerns in the first session.

SUMMARY AND CONCLUSIONS

Asian immigrants and Asian Americans will continue to avoid formal psychological services for mental health issues if the current paradigm of clinical psychology does not undergo a significant transformation. Hall (1997) reinforced this notion by stating that clinical psychology, based primarily on mainstream Euro-American beliefs and values, may become "culturally obsolete" unless it is revised to reflect a multicultural perspective (p. 642).

The review of literature supports this movement for a more culturally sensitive form of psychotherapy. The researcher used Bronfenbrener's Ecological Systems Theory (1992) of human development to organize the ecological factors involved in Asian immigrants and Asian Americans' formal help seeking. Research in the macrosystem included influences such as ethnicity and generational influences like acculturation. The exosystem included past researcher's work looking at stigma and shame associated with seeking formal psychological help for this population. The mesosystem included reviewed the influence of family structure, environment, and social support for the individual in seeking mental health treatment. Finally, the microsystem reviewed literature on the influence of the individual's age and gender. Across all levels (macrosystem, exosystem, mesosystem, and microsystem), majority of researchers have suggested that the aforementioned variables influence Asian immigrants and Asian American's likelihood to seek formal psychological treatment. The more likely the individual is to remain entrenched with these beliefs and values, the less likely the individual is to seek formal means of mental health treatment and vice versa (see Proposed Theoretical Model).

Furthermore, future research, education/training, and practice needs to be revised to reflect the researcher's findings regarding the influences in the individual's macrosystem, exosystem, mesosystem, and microsystem. Guidelines for the field of clinical psychology were

reviewed and discussed previously. Clinicians are encouraged to provide culturally sensitive psychotherapy, research, and training. I believe that psychologists should not only be encouraged to do this work, but more importantly, we should be ethically obligated to provide culturally sensitive psychotherapy. This would entail system changes in the current paradigm of clinical psychology, revising the current research and training/education to reflect the increasing multicultural society of the US. I believe that these changes will greatly influence the field and help decrease the gap between the service provided and the expectations of Asian immigrants and Asian Americans. This will increase the likelihood of individuals seeking formal psychological help for mental health issues.

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